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Charles W. McClure

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FLUORIDATION Part 2

Documentation Thoroughly Discredits It

MENACE TO HEALTH AND NEUTRALIZER OF MINDS

By John R. Lilliendahl, Jr., D.D.S.
Stamford, Connecticut

(Continued from Issue No. 423)

HARM TO HUMANS FROM FLUORIDATED WATER

McClure said (89): "The first specific symptom of fluorine injury to the child is the appearance of hypocalcified enamel known as mild mottled enamel." The AMA report gives mottling as "the most delicate criterion of harm" from fluorides and acknowledges that mottled teeth will inevitably result from water containing 1 ppm F (60). Dean (61) reported: "Teeth affected with mottled enamel . . . erupt showing a dull, chalky-white appearance which in many instances later take on a characteristic brown stain, the frequency of the stain increasing with age."

In 1941, Schour & Smith (62) discoursed on experimental dental fluorosis as follows: "In view of the multiple effects of fluorides upon teeth development (pigmentation, calcification, formation, eruption and attrition), the term 'mottled enamel' is insufficient and should be replaced by 'dental fluorosis.' The latter indicates the etiologic factor and includes the dentin as well as the enamel." While enamel formation ceases at eruption, this is not so with dentin and pulp tissue, where effects of fluoride can continue to increase throughout the life of the tooth.

Dillon (63) has shown fluoride to cause ectopic calcific deposits in the pulp and degeneration of the periodontal fibers as well as fluorosis of enamel and dentin.

Even though dental fluorosis is the first symptom of fluoride poisoning usually observed, it is impossible to tell, by dental fluorosis alone, whether or not the children showing it will later develop the other, more serious effects of fluoride poisoning. These other symptoms are so varied and so often associated with other conditions that nothing is pathognomonic of fluoride poisoning, except dental fluorosis, until catastrophic damage has been done. Shortt (64) says that death, in advanced cases, comes as a result of intercurrent disease. While the fluoride poisoning weakens and debilitates those afflicted, in reality it only makes them more susceptible to other things and it is this superimposed condition that actually gets credit for death. This is precisely why fluorosis is only rarely diagnosed as a disease entity and also why we do not find "fluoride poisoning—chronic" listed among death causes in mortality statistics. The impracticability of bone removal for analysis in living subjects also tends to lessen the likelihood of diagnosis of chronic fluorine intoxication.

It has been thought, until recently, that chronic fluoride poisoning would always be necessarily accompanied by substantial accumulation of fluoride in the bones. The discovery of the build-up of fluoride in the soft tissues (26) (27) and the finding of those studying the action of fluorides as

The Penalty For Going To Sleep



enzyme inhibitors (26) (80) (88) are making us aware of the fact that this is not always true that severe fluoride poisoning may occur without heavy build-up in bone.

McKay (66) told the American Public Health Association in 1952: "Fluorosis, even to an extremely disfiguring degree, can be produced when the fluoride content is two parts per million or more." This might seem to imply that below 2 ppm no disfiguring fluorosis occurs. McKay's own work (65) disallows any such implication. In 1916, he, with Black, found 100% mottling at 1 ppm F, 18% at 0.2 ppm, 50% at 0.4 ppm and 80% at 0.0 ppm. Finding mottling where waters contain no fluoride emphasizes the need for consideration of sources other than water in figuring total dosage.

BAD FOR THE UNDERNOURISHED

Massler & Schour (67) show that malnutrition exerts a severe influence on the degree of mottling resulting from low concentrations of fluorides.

Kemp, Murray & Wilson (68) observed that concentrations as low as 1 ppm F were associated with spinal deformations and damaging mottling. They also observed that poor nutrition accentuates the ill-effects of fluorides.

Boissevain (69), analyzing McKay's work, concludes: "Children less than five years old should drink water free from fluorine." McClure & Mitchell (70) found that 0.03% F. produces abnormal teeth in rats. Boissevain, discussing McClure & Mitchell's findings, says: "If the lesion in the rat teeth is

comparable with mottled teeth in the human . . . 2 ppm must be considered harmful to the general health." In the light of the knowledge of a 20 to 1 ratio of adult human water consumption, the lowness of this estimate is very thought-provoking, especially in view of the fact that fluoride can do adults no good whatever.

Kronfeld (71) writes. "Fluorine in low concentrations has a specific toxic effect upon the enamel-forming cells and also upon the calcification of the dentin. In cities in which the water supply has a fluorine content of from 0.6 to 0.9 part per 1,000,000, from 2.6 to 10.6 per cent of the children are affected." He indicates that mottling increases with increased fluorine content and admits that severe cases occur at low concentrations with "more susceptible" children.

One certain result of fluoridation, artificial or natural, is dental fluorosis. Newburg reports slightly more than 17% (72). Deatherage (72) found 31.8% of Geneva (1 ppm F), Illinois, children to have mottling. He found no simple relation between rate or degree of mottling and fluorine concentration of the water. Proponents have proclaimed that "no objectionable mottling" will occur under fluoridation, but who decided what is "objectionable"? No severe mottling has yet been reported in Newburg, but we have seen that the frequency of staining increases with age (61) (65) (66) (60). Those years have not yet passed.

The Smiths (73) consider water at 0.9 ppm F, or over, dangerous from a standpoint of mottling. They also discover no simple relation between fluorine content of water and fluorosis or dental decay. In Tucson (0.9 ppm F), Arizona, 37% of children had mild to moderate mottling. Indian children, drinking water at 1 ppm F, showed no less decay than children with much lower fluoride intakes, but their teeth were almost 100% mottled beyond repair. In studying the durability of mottled teeth at St. David, Arizona, 33% of 12-14 year old children were seen to have caries, but beyond 21 years of age very few were decay-free.

Fifty per cent (50%) of 24-26 year old people had false teeth because decay was so widespread and repairs so unsuccessful in fluorosed teeth. They felt that fluoride merely delays the time of appearance of decay, since they only rarely found fluorosed teeth of adults to be decay-free. Galagan (74) attributes the high mottling in Arizona to increased water consumption, which is in turn laid to the very high temperatures there.

In the foregoing, we have seen the occurrence of dental fluorosis of varying degree at all levels of fluoride occurrence in water, even those below the so-called optimal concentration. While dental fluorosis does not kill, it cannot be termed "harmless."

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—KHRUSHCHEV NEEDS THE MONEY

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Fluoridation: Do We Want It?

—o— Continued from page 1 —o—

SOME BAD EFFECTS OF FLUORIDATED WATER

Reported symptoms of fluoride poisoning are condensed below from Exner (6) and Waldbott (32):

1. Dental fluorosis, ectopic calcific deposits in pulp, periodontal disease.
2. Osteosclerosis, osteomalacia, exostoses, abnormal calcium deposits in and around joints and ligaments; together with severe nerve and muscle damage, which often produce disabling effects—including "poker-spine", which, however, may take as much as 40 years to develop. X-ray changes in poker back are severe.
3. Pain and stiffness in joints without x-ray changes.
4. Muscle pains, tenderness, weakness, shortness of breath, painful breathing.
5. Incoordination, altered reflexes, paresthasias, hearing loss or diminution.
6. Nausea, vomiting, diarrhea, anorexia.
7. Sterility, abortions, miscarriages, stillbirths.
8. Stunted growth, bow-legs.
9. Anemia, prolonged bleeding time, abnormal WBC counts and sedimentation rates.
10. Impaired liver and kidney function, goiter, cachexia, inanition and premature aging.
11. Taylor's work at the University of Texas (76) shows shortening of life spans.

Lemmon (77), pediatrician, of Amarillo (3.9 ppm F), Texas, reported: "Some of the babies have more tendency to bowing of legs, even in the face of constant anti-rachitic therapy, thus supporting the theory that toxic fluorides interfere with bone and dental metabolism."

KNOWN CASES OF FLUORIDE POISONING

Waldbott (32) described 52 cases of chronic fluoride poisoning from drinking water at or about 1 ppm fluoride.

Linsman & McMurray (78) gave an account of a death of an army sergeant from osteosclerosis due to drinking water. His first 7 years were spent in Spur (1.2 ppm), Texas, where he developed severely mottled teeth. The next two years were in Post (5.7 ppm), Texas, and then he lived for 7 years in Lubbock, Texas (4.4 ppm), moving to Washington (then unfluoridated), D. C., at 16 years of age. At 18 he returned to Lubbock, where he entered the army. He died of fluoride osteosclerosis at 22 years. A proper diagnosis would never have been made if an extraordinary post-mortem examination had not been done.

Pandit, et al (79), report the same diseased condition as Shortt (64), finding some cases occurring at fluoride concentrations as low as 0.6 ppm. Affected children, apart from mottling, showed no signs of fluoride

poisoning. At about 25-30 years a gradual onset of symptoms began: tingling, pain and stiffness over the body, resulting limitation of mobility of spine and thorax. At 30-40 years of age, the final stages appeared: cachexia, emaciation, pressure symptoms on spinal cord, impotence, loss of sphincter control, mental impairment. Finally patients are bed-ridden with death coming from inter-current disease. Important to note is that children slated for toxic manifestation show no signs of what is to come, except mottling.

FLUORIDE HARD ON HEART

Greenwood, et al (27), at Logan, Utah, studying effects of airborne fluorides, found fluoride deposits in the aorta. They noted: "As the degree of calcification of the aorta increased, there was a corresponding increase in the fluoride level. Fluorides are deposited along with calcium and phosphorus . . . the fluoride content of the aorta was higher than that of other soft tissues."

Ebert (80), studying metabolic pathways by which organs form embryologically, used sodium fluoride as an enzyme inhibitor. In low concentrations, it blocked, almost completely, the regions destined to form muscle, primarily affecting developing heart muscle. In high concentrations, it caused the entire embryo to disintegrate in a clear-cut pattern, starting with the heart-forming region. This causes us to remember that in the first 3 years of fluoridation, New Britain's (52) stillbirth rate jumped 150% while nearby unfluoridated Waterbury's rate remained unchanged.

Okushi (81) and Kono, et al (82), Japanese medical research men, produced severe myocardial damage in rats and white rabbits by feeding them 5-50 ppm F in foods. While these concentrations are greater than those recommended for fluoridation, the point is that in low concentrations, even less than 1 ppm, fluoride is cumulative and there may be damage as a result, damage that only controlled "in vivo" experiments will reveal.

FLUORIDE HARD ON KIDNEYS

Ramsyer (8) examined, at 520 days (equivalent to 42 years human age), 86 rats killed after living on drinking water at 1 ppm F continuously from birth. All of these animals had periodontal and questionable kidney lesions and all had more tooth decay than the controls. He concluded that fluorides at 1 ppm do not prevent tooth decay but that they do cause kidney and periodontal damage.

Rapaport (90), investigating the incidence of mongoloid births in Wisconsin, Illinois, and the Dakotas, found a definite relationship between the concentration of fluorine in the drinking waters and the frequency of mongolism. As fluoride concentrations were higher, incidence of mongoloid births rose proportionately and, further, with rising fluoride levels, the age of mothers producing

mongoloid children declined. These observations need no further comment.

Considering the mass of published evidence against fluoridation, it is strange to find astute medical men, like the composers of the St. Louis Medical Society Report, announcing that "There is no published record of any injury to the health of any person . . . etc." It is disturbing to see continued insistence on the utilizing of mass treatment of populations through water supply fluoridation, when such mass treatment is neither necessary nor advisable. It is also disquieting to hear capable scientists called "incompetent" and "biased," merely because their findings and beliefs happen to conflict with proponent scientists. There unfortunately appears to be no climate of professional opinion relative to fluoridation. Scientific findings and opinions cannot be dismissed by discrediting and personally directed slander,

CONSIDERATION OF "EVIDENCE" THAT FLUORIDATION WILL REDUCE DECAY BY 65-70%.

As proof of the efficacy of fluorides in decay reduction, proponents point to the "controlled" experiments at: Newburgh-Kingston, Grand Rapids-Muskegon, Evanston-Oak Park (in the U.S.A.) and Brantford-Sarnia (in Canada).

In scientifically operated experiments, calculated to determine the possible value of fluoridation, Sutton declares (83) the following basic conditions ought to be as nearly as possible satisfied:

1. Selected test (fluoride) and control (non-fluoride) cities must exhibit similarity in: size, climate, chemical composition of water supply, socio-economic status, basic (pre-test) decay rates and fluctuations therein.
2. Basic decay rates and fluctuations therein must be determined, for both test and control cities, prior to commencement of fluoridation in either.
3. A randomization procedure should be used to determine which city shall be test and which the control.
4. Decay rates should be taken in both test and control cities at regular times all throughout the test periods.
5. Groups of children for comparison should be of similar age, number, racial derivation—so as to prevent weighting of results (DMF rates).
6. The same examiners should conduct all examinations, examiners should be dentists, and they should use a standardized examination procedure.
7. Examiner bias should be eliminated by having examiners unaware of whether the children they are examining come from test or control areas.
8. Continuous residency for all children, test and control, should be ascertained.
9. Statistical adjustment procedures and devices should be standardized in all cases.

By these standards, our experiments are fiascos. In no case were basic decay rates determined for both cities before commencement of fluoridation in the test city. This meant that experimenters did not know whether the paired cities had similar basic decay rates until after experiments had commenced.

Fluctuations in basic decay rates were established prior to commencement of experiments in no instance. A randomization procedure was in no case utilized.

Water analyses were stated in no case beyond fluoride level determination. It was stated, in the Newburgh-Kingston case, that the waters for the two cities were similar, but here is how similar the 1952 U.S. Geological Survey shows them to be:

Newburgh (test), 35.0 ppm (calcium), 3.6 ppm (magnesium), 102.0 ppm (total hardness).

Kingston (control), 6.6 ppm (calcium), 0.9 ppm (magnesium), 20.0 ppm (total hardness).

Dissimilarities are here obvious. Newburgh fares much better in both calcium and magnesium, minerals essential for good tooth and bone formation.

THE SUNDAY ENTERPRISE (Beaumont, Texas)



INADEQUATE TESTING METHODS

In the Evanston-Oak Park test, initial basic decay rates were found dissimilar, and here again the basic decay rate was not determined for the control city until after fluoridation had commenced in the test city. In the case of Grand Rapids-Muskegon, basic decay rate for Muskegon was not determined until fluoridation had commenced in Grand Rapids. Further invalidation is seen in the fluoridation of Muskegon, the control, midway in the experiment.

No provision to eliminate examiner bias was utilized in the tests. Examination methodology was inconstant. Data was improperly grouped. Fluctuations were disguised in control cities since usually only two DMF studies were done in control cities—one at the beginning and the other at the end of testing periods. The make-up of the examination teams was very inconstant. "Groups" for comparative purposes ranged in number from 1 to over 1800. Weighting could not help but result from the improper grouping of children age-wise. Continuous residence was often merely assumed, or disregarded altogether, and improper and inconstant analytical and statistical adjustment procedures were observed.

Feltman, Kerwin, London, and others (8) have all criticized the DMF yardstick used in these trial tests by examiners, saying that it is unreliable since dental examiners rarely agree on the DMF of a given child.

Paluev (84) gave a highly critical summation of fallacies he observed in the trial at Newburgh-Kingston and Grand Rapids-Muskegon. He said that delays in appearance of decay were recorded as decay reductions, the method of expressing DMF reduction by percentages is fallacious, and the method of averaging DMF reductions is deceiving.

Dillon (85), using the Public Health figures, shows the actual increase in the sound teeth at Newburg as a result of fluoridation was not 77.6%, as stated by the experimenters, but, rather, only 7.2%. He shows that the percentage DMF decrease falls rapidly as age advances, and says: "In omitting to compare the rate of deterioration of the dentition before and after fluoridation, Public Health Authorities have omitted to deal with perhaps the most important aspects of caries control."

Klerer (47) also criticizes these tests and concludes, as do Dillon, Paluev, Sutton, etc., that the manipulation of data by official Public Health evaluators is so flagrant as to make ridiculous the claim of an average 60-70% reduction of decay by fluoridation. He says that the most that can be proven by these tests is a slight delay in the time of appearance of decay.

PUBLIC RESISTANCE TO FLUORIDATION GREATER NOW THAN EVER

That fluoridation is unpopular is shown by the many cities which have discarded it after trial periods. Referenda, where people are given a chance to accept or reject it beforehand, more often than not, result in rejection.

People can understand compulsory mass medication where communicable disease is involved, but they cannot see forced ingestion of any cumulatively poisonous material by 100% of people in order to benefit the less than 10% who are 8 years and under. They say fluoridation is a form of government medicine by edict—bureaucracy at its worst. Is it any wonder that they yell "rat poison," and worse, when they know that Public Health officials have made mistakes in the past.

FLUORIDATION—MAY IT PASS TOO

They remember when iodine was recommended for addition to water supplies to combat goiter. They also remember that it had to be discontinued, after trial, when it was seen that iodine made some goiters much worse. For years the Public Health condoned the use of di-ethyl stilbestrol, a synthetic female hormone used for fattening poultry and beef cattle, in spite of the fact that scientists warned of its cumulative build-

up and carcinogenic action in humans (52). Now, it has belatedly been banned. It is to be hoped that fluoridation, the pollution of potable waters with a cumulative poisonous material, more toxic than arsenic or lead, will suffer a similar fate. People would like the privilege of selecting "their own poisons."

The unpopularity of fluoridation in scientific circles is not quite as readily apparent, possibly since this seems to be the "age of conformity", wherein even scientists dislike being called names because they disagree with commonly expressed views. At the 19th Eastern States Health Education Conference, New York City (86), one very scientific proponent, a sociologist, said opponents of fluoridation could be characterized largely as lower middle-class persons, disturbed over their rank in society. "They belong to the so-called radical-right that tends to support Fascist and Neo-Fascist movements and to oppose authority in general," he said. A second proponent, a psychiatrist, pictured opponents as: "Individuals who just oppose . . . the sort of person who would scratch a match across a 'No Smoking' sign." I include these last two remarks merely to demonstrate the sort of atmosphere engendered by the emotionalism and name-calling proponents. In the face of such "scientific reasoning", is it any wonder that scientific men opposing fluoridation, or having mental reservations with regard to it, are often reluctant to be classed among the "nit-wits"?

Some of the distinguished physicians, dentists and scientists who express criticism of fluoridation are:

Jonathan Forman, MD, former editor of the Ohio State Medical Journal.

A. Benagiano, Professor and Director, George Eastman High Institute of Odontology, Rome, Italy.

Geoffrey Dobbs, Ph.D., ARCS, Microbiologist, College of North Wales, Great Britain.

Phillip R. N. Sutton, D.D.Sc., Oral Medicine and Surgery, Dental School, University of Melbourne.

Charles Dillon, D.D.S., L.D.S., Inverness-Shire, Scotland.

T. Gordonoff, M.D., Berne, Switzerland.

Simon Beisler, M.D., Chief of Urology,

Roosevelt Hospital, N.Y.C.

Alfred Taylor, Ph.D., Biochemist, University of Texas.

Clive McCay, Ph.D., Professor of Nutrition, Cornell University.

F. B. Exner, M.D., F.A.C.R., Past President, King County Medical Society, Washington.

Reuben Feltman, D.D.S., Passaic General Hospital, Passaic, N.J.

Dr. Hugh Sinclair, Oxford University, England.

George L. Waldbott, M.D., Allergist, Detroit, Michigan.

Arthur C. Ford, D. Eng., President Board of Water Supply, City of New York.

The foregoing list of names is given not to impress readers with the number of scientists opposing fluoridation, but rather the quality of opponent scientists.

In summation of the facts apparent on consideration of material presented in this report we might say:

1. Fluorides are nonessential to humans and they do not improve water.

2. The toxicity of fluorides is of higher order than arsenic or lead in all three respects: (1) Acute, (2) Allergic, and (3) Chronic-cumulative.

3. There is no such thing as a "safe level of fluoride" in water. Therefore, the "optimal" level is zero.

4. Due to cumulative action, harm results from fluorides at any level of intake.

5. Evidence purporting to demonstrate decay reduction by fluoride is unscientifically founded.

6. Fluoridation of potable public waters is mass-medication and is generally unpopular.

THE SOLUTION TO THE PROBLEM

Administration of fluorides to humans is without proven benefit in caries prophylaxis. In addition, we may be certain that some harm will accrue to at least a segment of the population under fluoridation of public drinking water. It, therefore, seems unwise to recommend fluoride use to anyone.

It must be recognized, however, that some individuals will, nonetheless, desire to be fluoridated. The need, then, is for a more

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To Whom It May Concern:

I, Oliver Kenneth Goff, was a member of the Communist Party and the Young Communist League, from May 2, 1926, to October 9, 1939. During this period of time, I operated under the alias of John Keats and the number 18-B-2. My testimony before the Government is incorporated in Volume 9 of the Un-American Activities Report for the year 1939.

While a member of the Communist Party, I attended Communist underground training schools outside the City of New York, in the Bues Hall, and 113 East Wells Street, Milwaukee, Wisconsin. The East Wells Street School operated under the name of the Eugene Debs School. Here, under the tutoring of Eugene Dennis, M. Sparks, Morris Childs, Jack Kling and others, we were schooled in the art of revolutionary overthrow of the established Government.

We were trained on how to dismantle and assemble mimeograph machines, to use for propaganda purposes during the revolution; how to work on guide wires and fuel lines of airplanes so that they would either burst into flames or crash to the ground because of lack of control; how to work on ties and rails to wreck trains; and also the art of poisoning water supplies.

We discussed quite thoroughly the fluoridation of water supplies and how we were using it in Russia as a tranquillizer in the prison camps. The leaders of our school felt that if it could be induced into the American water supply, it would bring about a spirit of lethargy in the nation, where it would keep the general public docile during a steady encroachment of Communism. We also discussed the fact that keeping a store of deadly fluoride near the water reservoir would be advantageous during the time of the revolution, as it would give us opportunity to dump this poison into the water supply and either kill off the populace or threaten them with liquidation, so that they would surrender to obtain fresh water.

Oliver Kenneth Goff
Oliver Kenneth Goff

STATE OF COLORADO)
) SS
COUNTY OF ARAPAHOE)

OLIVER KENNETH GOFF, being first duly sworn upon his oath, deposes and says that he has the above and foregoing instrument and knows the contents thereof, and that the same are true of his own knowledge except as to those matters stated on information and belief and as to those he believes them to be true.

and sworn to before me this 22nd day of June, A.D., 1957.
My commission expires April 14 1958



Oliver Kenneth Goff
Joe P. Hansen
Notary Public

Fluoridation: Do We Want It?

—o— Continued from page 3 —o—

selected application of fluorides that would allow individuals desirous of the alleged benefits of fluoride to attain them while they, at the same time, do not interfere with those wishing to remain unfluoridated.

A simple solution, that would interfere with the rights and desires of no individual, is what Ohmart (87) has called "personal fluoridation", the administration of tablets of known dosage, to be swallowed as a pill or dissolved in a diluent of choice.

In 1946, Arnold stated: "It is easy and simple to get 1 ppm added fluorine into a child's diet by the use of standard fluorine tablets administered by the parents." If it was easy and simple then, it can be no less so now.

Nesin (38) has described various ways of providing fluoride intake for dental caries prevention in children. He feels the tablet method of administration best because:

1. Tablets allow for the greatest possible degree of dosage accuracy.
2. Tablets allow for the use of a vehicle of choice.
3. Tablets can be used with nearly equal facility in both urban and rural areas.
4. Tablets may be selectively applied so that only those who can benefit need partake.
5. Tablets allow for easy discontinuance of therapy by individuals evincing susceptibility.
6. Tablets provide a much higher degree of economy than water fluoridation. Comparative costs for New York City, as stated by Nesin (38), are \$110,000 per year for a tablet program as against over \$1,000,000 per year for water fluoridation chemicals alone, with the initial cost of equipment (\$445,000) and the yearly maintenance costs additional.
7. Tablets allow an individual to decide for himself whether or not he wishes to become fluoridated.

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